



Michigan Mental Health Commission

established by Governor Jennifer Granholm's Executive Order 2003-24

MENTAL HEALTH COMMISSION MEETING SUMMARY

June 28, 2004

Holiday Inn South Convention Center

Lansing, Michigan

Commissioners Present

Patrick Babcock and Waltraud Prechter, Co-chairs; William Allen, Fran Amos, Elizabeth Bauer, Beverly Blaney, Thomas Carli, Nick Ciaramitaro, Bill Gill, Rick Haverkate, Joan Jackson Johnson, Gilda Jacobs, Alexis Kaczynski, Guadalupe Lara, Sander Levin, Kate Lynnes, Milton Mack, Samir Mashni, Andy Meisner, Janet Olszewski, Donna Orrin, Jeff Patton, Brian Pepler, Michele Reid, Mark Reinstein, Roberta Sanders, David Sprey, Sara Stech, Rajiv Tandon, Maxine Thome, Marianne Udow.

The meeting was convened at 8:40 AM. Patrick Babcock called the meeting to order and reviewed the agenda for the day. Mr. Babcock thanked the work groups for all the hard work that went into developing the key issues that are before the commission for deliberation during a facilitated discussion that will comprise the majority of the day's meeting. Mr. Babcock asked commissioners to consider the values they identified as a group as they discuss and prioritize the key issues.

Approval of May 24 Meeting Summary

The summary of the commission's fifth meeting (May 24) was reviewed by Kate Lynnes. Jeff Patton asked that his name be added to the list of commissioners present at the meeting. It was also noted that the NAMI walk on May 23 was in recognition of National Mental Health Awareness Month and was held in Belle Isle. The full meeting summary was then approved by a unanimous vote.

Updates

Robert Bernstein Letter to Patrick Babcock

Mr. Bernstein wrote a letter to Pat Babcock encouraging an ambitious approach for Michigan's Mental Health Commission. Mr. Babcock said the letter includes good examples of approaches being used in other states to improve their public mental health systems. In particular the letter suggests that the commission make recommendations that are person centered.

In support of the contents of the letter, Mr. Babcock said that MDCH has put together a CD-Rom with examples of best practices to be shared with the commission.

NAMI Picnic

Commissioners have been invited to attend the upcoming NAMI of Southwest Michigan picnic and have a short business meeting prior to the picnic. More information will be forwarded to commissioners soon.

Long-term Care Task Force

Governor Granholm has appointed a Long-term Care Task Force, and commissioners inquired as to whether there will be any coordination between the task force and the Mental Health Commission. Mr. Babcock responded that there will be linkages, but it is not yet clear what those will be. Mark Reinstein raised a similar question regarding the governor's new Medicaid Task Force. The commission was informed that the task force was having its first meeting today (June 28). Mr. Babcock also said that he is attempting to arrange a meeting with Michigan's Surgeon General to discuss potential linkages between the commission and the governor's Healthy Michigan initiative.

Vision, Values, Report Outline, Key Issues Review and Prioritization, and Next Steps

Vision

The Project Management Team reviewed an early draft of a vision statement, which was handed out for the commission's review and comment. It was agreed that the commissioners will need to craft a vision statement they can all support. Commissioners were asked to provide comment on the draft vision statement in writing or by e-mail to Public Sector Consultants. The vision statement will be discussed at greater length at a future commission meeting.

Report Outline

The commission reviewed a draft outline for the report the commission will submit to the governor. The outline is the result of work done by the Project Management Team to provide a framework for the recommendations being developed by the commission. Although it is a work in progress, it should help add focus to the commission's deliberations.

Values

The co-chairs reviewed the process for the review of each work group's key issues. They reviewed the values the commission developed and stated that they should serve as a filter for assessing the key issues. One commissioner noted that he had reviewed the values and found them inspiring, comprehensive, appropriate, and meaningful for the next 20–30 years. Upon review of the work groups' recommendations, however, he found a significant gap between the values and the recommendations. He stated that the commission needs a formalized mechanism for working with MDCH to implement the recommendations. The commission should consider recommending the creation of two statutory bodies—one to follow up on the recommendations of the commission and the other to serve as a resource center for evidence-based practices. The second body would be a resource to MDCH and the first statutory body.

Other commissioners noted what they felt were important considerations for the rest of the work of the commission:

- The commission should consider how its recommendations may affect populations other than those with mental illness and serious emotional disorders (e.g., the developmentally disabled and persons with traumatic brain injuries).

Pat Babcock suggested that using the values to guide deliberations should help to guard against the possibility of unintended consequences.

- A special effort should be made to involve recipients and their families in the process of developing recommendations. To this suggestion, Pat Babcock responded that the commission will be holding a meeting in August with half of the day set aside for public comment.
- The commission needs to find a balance between being overly cautious about making recommendations that require significant funding increases and making bold forward-thinking recommendations that may not be feasible immediately but may be good recommendations for the future of the public mental health system.

Key Issues Review and Prioritization

The co-chairs explained that Peter Pratt of Public Sector Consultants would facilitate the key issues review and prioritization. They suggested that the review would provide the commission with an opportunity to see the work of the full commission to date and to assess the priority of each issue.

Mr. Pratt told the commissioners that they should keep three key questions in mind when reviewing the key issues:

- What are the gaps?
- What refinements are needed?
- What are the cross-cutting issues?

Presentation of Key Issues by Work Group Chairs

The chairs of each work group presented a brief overview of their key issues for the commission prior to the full commission discussing each of the key issues in more detail.

Education, Rights, Outreach, and Advocacy

- A. Inadequate rights protection.** The current recipient rights system does not adequately protect the rights of consumers and their families.
- B. Public attitudes and stigma:** The pervasive public stigma about mental illness negatively affects allocation of federal, state, and local funding; access to treatment and support services; the quality of diagnosis and treatment; education; employment and the availability of affordable, equitable health insurance.
- C. Accountability:** The public mental health system is not sufficiently accountable to applicants, recipients, or the public.

Services and Supports for Children and Families

- A. Underfunding:** The current system is significantly underfunded. As a result, efforts to contain cost result in state and local policies and procedures that encourage inappropriate handoffs among systems, including, but not limited to, mental health, juvenile justice, child welfare, substance abuse, and education.

- B. Lack of a continuum of services:** Michigan lacks a comprehensive spectrum of mental health and other necessary services to meet the needs of children and adolescents with or at risk of SED. There are barriers to accessing children's mental health services. The mental health system lacks well-developed collaborative systems of service with the child welfare, juvenile justice, substance abuse, and education systems.
- C. Inconsistent use of standards of care and best practices:** Agencies providing mental health services to children and families within the system of care do not share consistent standards of care, nor do they consistently use best practices.

Services and Supports for Adults

- A. Access to treatment services and supports (quantity):** Treatment, services, and supports for adults and older adults are not uniformly available in the appropriate quantities to meet the mental health needs of Michigan residents.
- B. Quality of treatment services and supports:** The current system does not allow for continuous assessment of the quality of treatment, services, and supports for adults and older adults.
- C. Accountability:** The quantity and quality of treatment, services, and supports for adults and older adults is uneven and not uniformly based on evidence or best practice models.

Criminal Justice and Human Service Interface

- A. General (overuse of costly and inappropriate services):** There is an inefficient use of taxpayer dollars as we overutilize an expensive criminal justice system, rather than provide more appropriate and cost-effective mental health assistance/services.
- B. Pre-entry:** In advance of an individual coming in contact with either the juvenile or criminal justice system, we do not adequately assess or use early risk factors, or symptoms of mental illness, in order to address problems before they become more serious.
- C. Diversion:** The present statutory and administrative framework is insufficient to achieve real juvenile justice and criminal justice diversion. The access, entry, and treatment systems of mental illness and substance abuse are not integrated well for those who are dually diagnosed. Responsibility for mixed-county cases (when the county of adjudication is not the county of residence), relative to the provision of mental health services, is unclear.
- D. Incarceration and detention:** Within jails, prisons, and juvenile detention facilities there are problems with timely and accurate clinical screening and assessment and treatment. Treatment is often inadequate and inappropriate.
- E. Upon release:** As a person moves from detention/incarceration to community-based treatment and care, there is no unified system of coordinated and collaborative support to ensure a smooth and successful transition.
- F. Beyond the criminal justice and human service interface:** Public policy provisions regarding involuntary treatment are inadequate to permit the mental health system to treat many seriously ill people. There is no effective or consolidated mechanism for

researching and collecting established national “best practice” models and translating them into Michigan operations.

Governance, Structure, and Accountability

- A. Structure and governance:** Michigan’s public mental health system is not structured to deliver care equitably, effectively, and efficiently to people with mental illness. There is an unacceptably wide variation in funding and access to care across counties. Administrative redundancy and a lack of standardized reporting requirements divert monies that could be better spent on direct care.
- B. Funding:** Public mental health services are funded through many streams, each with its own rules and regulations. Michigan’s maximization of Medicaid has been accompanied by reductions in base general fund support for mental health services. Inadequate funding has led to limits on access to care for persons in need.
- C. Accountability:** There is too much unproductive variance in the quality of mental health care, payer reporting requirements, and other administrative requirements.
- D. Longer term care:** Licensure changes are necessary to create new kinds of facilities and services to meet longer term needs of persons with mental illness.
- E. Involuntary treatment/commitment:** The current process for involuntary commitment poorly serves consumers and the public interest. Involuntary treatment should be used only as a last resort. An alternative is needed that preserves self-determination while creating a sensible, effective, clinically driven process to provide care to persons who do require involuntary treatment because they are a danger to themselves or others.
- F. Prevention and early intervention:** There is much evidence that people with mental illness benefit from early intervention and yet it is drastically underfunded. Currently, a person must be in crisis to receive care in the public mental health system.

Facilitated Dialogue to Refine Key Issues

The following is a summary of the discussion of the key issues.

Education, Rights, Outreach, and Advocacy

A. Inadequate Rights Protection

Question: Is the recipient rights program inadequate? Is there data to demonstrate this or just anecdotal stories?

Response: Countless public comment over the past 20 years has noted this problem. In fact, much of the public testimony presented to this commission detailed problems with the recipient rights system and general accountability. It is at least a very important issue, even based on the appearance of conflict of interest. This work group will contact Michigan Protection and Advocacy Services (MPAS) to obtain hard data on the failure of the current rights system.

Rep. Andy Meisner offered that his office did some research on recipient rights to find out how the state monitors Wayne County. Minimally, the commission could use the research to see what kind of grades the state is giving the Wayne County office regarding recipient rights.

The inability of the state rights office to enforce workable sanctions against CMHSPs with histories of rights violations is a problem. The system needs a rights office with “teeth.”

Question: What are the differences between MPAS and the state recipient rights office?

Response: They have different missions. MPAS is responsible for responding to rights violations. MPAS has authority to access any venue where someone is receiving treatment. The recipient rights system is responsible for ensuring that laws/rules are enforced.

The detailed recommendations of the Education, Rights, Outreach, and Advocacy Work Group offer responses to the issue of inadequate rights protection. The recommendations do not focus only on the conflict of interest in the current recipient rights system in the state.

It should be noted that there are two statutory bases for recipient rights protection: Mental Health Code and Social Security Act.

Some states have taken the option of making protection and advocacy internal. States, such as New York, that have an internal protection and advocacy system contract with legal service corporations in the state to provide legal protection. Protection and advocacy has to be independent from service providers to be effective and objective. Most states have independent/external protection and advocacy systems. California made its recipient rights system external so that protection and advocacy is a separate department.

B. Public Attitudes and Stigma

Question: What does the group mean when it suggests leveraging Michigan’s resource and development resources?

Response: In Michigan, we have a remarkable ability to be a center for brain science research using the life sciences corridor. We should turn ourselves into international resource. It would help drive away stigma.

Services and Supports for Children and Families

A. Underfunding

This is a key point for the children’s work group. Funding will lead to ability to address other issues more readily. We have data to support this.

Funding is a two-part issue. If you’re Medicaid eligible, funding may or may not be adequate. If you’re not, funding is likely to be inadequate. Just to say the system is underfunded oversimplifies it. Isn’t underfunding based on status?

From our standpoint, if the funds are there then we can provide the services early on.

The idea of braided funding is a good one. More potential funding pots are out there for children. How do you put together collaboration to work with braided funding?

The group is suggesting that funding for children's mental health services is inadequate and the current structure leads to handoffs and inadequate care. One of the points the group makes is that the structure leads to fragmentation.

We have a situation where services are more expensive later on. If children were identified sooner and received services sooner, a lot of money could be saved.

We are hearing things in this discussion that aren't captured in the key issue summaries (e.g., services are not provided early enough).

The summary statement for the children's work group doesn't reflect everything we've discussed. An enormous piece of the underfunding issue is that we spend millions of dollars on inappropriate services.

The system would have money for early intervention if it weren't being spent on the opposite end of the spectrum.

We presume there is adequate diagnosis of disorders. It is important to have better diagnoses of children before we determine what kind of services they need.

B. Lack of a Continuum of Services

The lack of a continuum of services issue needs to be enhanced. Education fails to perform its responsibilities to kids with SED. Certain services are supposed to be required of schools, but they are not done and then the responsibility falls to the public mental health system.

The same issue is being raised in the adult services group.

Is the issue clearly stated so that we are talking about the state continuum and regional variation? What did the work group think about knowledge-based research? Is that role for a body within the current system or for universities?

We talked about using universities.

C. Inconsistent Standards of Care and Best Practices

A combination of this issue and the previous one relate to stigma. Information has not consistently gotten out that children do have mental illnesses.

We should rely less on current diagnostic classification (DSM IV), which relies more on symptoms. Some diagnoses are overused.

Disorders that get addressed are those in DSM IV. We need the diagnoses so that kids get served early enough. There is too much effort to rule out diagnoses.

DSM is perhaps inadequate as we are learning more about etiology of illness. There will be changes in the diagnostic system in next ten years. A statutory body on best practices may be useful in that regard. Questions that need to be asked are: Are children being overprescribed medications for mental illness? What is the standard of practice on medication for children? What is our stance on this issue that we want to disseminate to providers of mental health care for children? We ought to formulate an opinion and answers to these questions to disseminate.

To a great extent this addresses how we put together a system of checks and balances. Today, medications are designed to be useful in allowing people to live good lives rather than serving as a chemical straightjacket. We just need a system of checks and balances to look at overuse/underuse of prescription medications.

The key issues and recommendations of this group are meant to address not just young children and adolescents, but also the entire age span from birth to age 18. Kids are kicked out of day care and preschools. This should be a red flag to screen them for SED.

There are some fundamental questions the commission hasn't addressed. We've made some assumptions. Are we all clear about what populations we are serving? Are we clear about diagnostic range the public mental health system is responsible for? We need clarity about range that we are accountable for.

The work groups are saying the code is insufficient. The system shouldn't just address severe and persistent mental illness.

A recommendation may be to create a coalition including universities to obtain and disseminate information on best practices. The Rights work group's options include a coalition like this.

People with mental illness may lose custody of their children, which is a disincentive to receive care.

Supports and Services for Adults

A. Access to Treatment, Services, and Supports (Quantity)

We need to know who we are serving and what are we serving them for to address the quantity issue. Questions that should be answered are: What treatments do we have available with what outcomes in mind? How are we going to evaluate the outcomes?

The values statement clearly states we are going to serve everyone. The values are not limited to any group. The values answer the question, but the issue is how we are going to do it.

Money and other limitations enter into this. If we have limited resources and we have to make rationing decisions, then rationing toward those with most severe illnesses makes sense. We can't address what the barriers to access are if we don't determine who we are serving.

A major part of the problem is the Mental Health Code. We may need to make recommendations to amend the code to address people with less severe mental illness.

The definition in the code had little to do with economics. It had more to do with moving the inpatient population into the community during de-institutionalization.

In the long run we should be developing a system that serves all. As a commission, we agreed a long time ago to develop an ideal system. We can't afford not to fund and provide prevention efforts.

The general public hasn't been aware that the state made a conscious design shift to being a primarily Medicaid-funded mental health system for the seriously mentally ill. As family members fight to get needed treatment for their loved ones there is less money for early intervention and diagnosis. The definition of SMI doesn't necessarily mean that you should receive treatment only when you are demonstrating symptoms. A person diagnosed with schizophrenia should be able to continue to receive treatment even when they are doing well, so they can avoid a crisis from the illness.

As a commission it is our charge to make recommendations to the governor on how to fund the actions we propose.

Nowhere in our charge does it say we have to stick to recommendations that are currently fiscally feasible.

The commission needs to recommend ways to increase access to private providers through insurance. The insurance commissioner should be included in collaborative arrangements.

We need to improve access for the homeless population.

Questions that need to be answered are: What is the essential core of services that should be available within a certain distance (i.e., people should not have to drive more than 60 minutes, one way, for services), and what is the optimal core? How do all the agencies fit into the funding plan?

B. Quality of Treatment, Services, and Supports

Question: Quality of treatment for what? If we are committed to providing services for all, we need to define what we need improved quality of treatment for. We may already have good quality treatment for some things but not for others. How do we make the decision of what we need better treatments for?

The Rights work group is recommending a new rights office with the function of developing statewide, uniform programs for measuring service quality and other key factors. The office would also develop statewide client surveys that would not be performed by CMHSP staff. Current data is not transparent.

The Adults Services work group is saying the same thing. It is not the perception of the public that high-quality services are there. Data is based largely on those who are getting services, not those who are not. There should be a way to track those who are not getting services.

Whatever the data we are requesting, the department needs the teeth for imposing sanctions.

Based on the key issues identified by these work groups, it appears no performance indicators are quite good enough. CMHs do have systems in place to improve quality. But what incentives are lacking to move them toward improving services and providing high-quality services?

The biggest issue is the lack of transparency. Information about the quality of treatment and services is confusing and not easily understood. The public perception is that nothing is going on to improve services.

Question: JCAHO is using tracing surveys for health care. Is there anything comparable for use in the mental health system?

Response: I don't think so. With the limited number of staff at the state level it seems unreasonable to go to that detail. What needs to be determined is what type of data collection system will give us the biggest bang for the buck.

C. Accountability

Sanctioning by taking away funding hurts those who aren't at fault—the consumers. The Rights work group has discussed giving the new rights office the power to put a CMHSP in receivership so that clients will not be hurt while reforms are implemented.

This work group should use recommendations that we heard from the dementia group during public comment this morning to address accountability issues.

We really should find a way to track all the money that is being spent on consumers in the mental health system. The only thing we're doing in many cases is pushing people into higher cost services.

If we make recipient rights one-stop-shopping, everyone is accountable. Now that the CMHSPs are authorities and have pseudo-governmental immunity, services are provided by contractors and that is a concern as far as accountability.

We need to consider best practices with regard to quality assurance. We should determine what the outcomes are of current services. One way to get the information is to interview and get direct feedback from clients and get that information back into the system quickly.

Criminal Justice and Human Service Interface

A. General (Overuse of Costly and Inappropriate Services)

The work group should specify that this is an issue for children as well as adults.

Question: Is there evidence to support the claim of overutilization of the criminal justice system?

Response: Community mental health boards and others have conducted several studies.

Question: Why did the group choose to use the phrase “expensive criminal justice system” when the mental health system can be expensive, too?

Response: When our group was comparing costs, we looked not only at direct costs, but also at costs to society, which is likely higher if people have been allowed to reach the criminal justice system. We determined that the cost benefit is better if people are treated in the mental health system.

More neutral terminology may be necessary. Sometimes the mental health system can be as or more expensive. The group's main point about working to get people into a system that can better serve them is a good one.

In addition to mental health issues, approximately 70 percent of people in jails have co-occurring disorders.

A survey by the sheriff's association was conducted in the mid-90s and was followed up with a survey conducted by the Board Association to look at the correlation between jail and prison rates and de-institutionalization. Some studies show no correlation between prison entry rates and de-institutionalization but there are correlations between de-institutionalization and jail entry.

B. Pre-entry

Question: Did the group look at lack of parity as obstacle to interaction with the private sector?

Response: Obviously that's part of the problem. We were concerned with both the lack of prevention and the lack of interaction between the private and public sectors. It seems that people with mental health issues are either in one system or the other.

Concern was expressed with last sentence of this key issue. ["Also, a number of people in the community do not recognize that their own mental illness may result in behaviors that may lead them into the criminal justice system."] The sentence seems only to add to stigma.

It's an important part of problem, but it's not that they don't recognize the illness, but that they have agnosia, a symptom that leads them to deny their illness.

It's expensive to provide treatment to people with mental illness.

We're trying to say the opposite. If we provide treatment early on, we'll save the taxpayers money.

C. Diversion

There is a disparity between jails and prisons. How do we fix that? The issue goes beyond a public mental health system fix.

The work group did not get to that issue but we should look at it in more detail. The Mental Health Code requires the justice system to have a diversion program but it doesn't require other agencies to participate in working on diversion.

The problem is that the current mental health system brands you by your county of origin for a lifetime. [Referring to issue of responsibility for mixed-county cases.]

Services should follow a person wherever they go.

That's an important issue and it covers all our subissues.

D. Incarceration and Detention

Question: Does the work group's plan include Memphis model training for officers in terms of improving response to those with mental illness?

Response: When you see the detail of our recommendations you will see a great deal about training first responders. We talked a lot about the disparity across counties of the availability of mental health services within jails. There is a disconnect between the types of services people receive as they move through the system.

There have been recent reports of inappropriate seclusion and restraint of people with mental illness in jails. Officers really didn't understand what was going on and that what they were doing was making the situation worse. This is an important consideration for training.

E. Upon Release

There is an identification problem. People in jail/prison are not always identified as having mental illness and then when they are released they often can't get jobs or housing. We have to fix that.

We should start planning for release from day one. One of the problems you have is that you may be eligible for CMH treatment, but you have a start-stop situation between counties. An overall problem is that when you're in prison you're not eligible for Medicaid.

One of the consumer members of this work group raised the point that when he was incarcerated he was getting negative points in parole for taking psychotropic medication. In some cases prisoners were advised to stop taking their meds. This is no longer the case, but it demonstrates the stigma issue that if someone is ill enough to require medication, they are assumed to be dangerous.

If people are not stable at the time of arrest, they are vulnerable to abuse in jail. They can be victimized easily.

In some cases people with mental illness need to serve jail time to have repercussions for their actions. But in some cases we are using the jails/prisons inappropriately.

One of the issues this work group spent a lot of time talking about is the difficulty of getting appropriate medications to people in jail. It has to do with the rules in the jails.

F. Beyond the CJ and HS Interface

One of the reasons people are not compliant is they have had a negative experience. When you're well enough to spell out what you want to happen to you through an advanced psychiatric directive, you feel more in control. This could help limit the need for involuntary inpatient/outpatient treatment.

This is clearly a point of tension. On the one hand we want to discourage use of involuntary treatment but on the other hand we recognize that certain kinds of serious mental illness impact the ability of people to admit they need treatment. What should the parameters be? The Mental Health Code needs to be clarified with regard to involuntary

treatment. We talked about mental health courts as an answer to this issue. In a mental health court, the judge will have the necessary information in front of him/her and may be able to suggest alternatives to incarceration.

This brings to mind Kevin's Law. If someone is committed involuntarily, there should be an independent second opinion. If people with mental illness have advanced psychiatric directives it would decrease the likelihood that they would end up in treatment without their consent. We need involuntary commitment for cases of substance abuse similar to the process in Florida.

With regard to mental health courts, this is not akin to involuntary treatment. It's more of a plea bargain opportunity. The judge offers opportunity for treatment rather than criminal proceedings. In a sense it is diversion.

Governance, Structure, and Accountability

A. Structure and Governance

It seems a basic issue is whether we need an *optimal* structure or a *basic* structure to address these issues. This discussion occurred regarding special education. We would not have used the term "optimal" but we were looking at what was *necessary* to change the system. And in that case there was a lot of money available for making changes. I am surprised by the way we run the mental health system in Michigan. It relies so heavily on Medicaid that it raises the issue of how much the source of money shapes the structure rather than the structure determining the source of money. It seems to me that a necessary structure would address all the issues that come before the reference of "optimal" in the key issue summary statement of this work group. I also question the potential use of an 1115 waiver. We need to consider how much we will rely on Medicaid.

It seems that the necessary ingredients are eliminating redundancy, starting with strengthening consumer involvement, and squeezing every dime possible out of the administration.

Form should follow function, but in this case form follows money. Our work group is suggesting the form of the mental health system should be based on the values the commission outlined. Michigan's public mental health system should address the values and issues identified by the commission.

Over the past several years, Michigan's public mental health system has evolved into primarily a Medicaid-funded system.

The adult work group talked about a secondary issue to do with structure and governance. When mental health existed as an agency there was more visibility in terms getting issues addressed.

The dominance of Medicaid is not just Michigan specific. How do we change it? This will have to be a recommendation coming from the group. There are values we haven't talked about. Should we change the structure? Is there value to restructuring the CMHSPs through consolidation? Do we have an efficient system when we have two tiers?

Concern was expressed about the comments that Medicaid dictates the system. CMHSPs existed prior to Medicaid, but PIHPs did not.

The system is heavy on administration and there are significant concerns about movement away from local control. There is serious concern about reduction from 46 CMHSPs to 18. We value community-based services. This would impact the ability to have local control and collaboration. It is important to have community involvement.

There is a concern about losing local *delivery* of services, not so much about losing local *control*. The state has a responsibility to set minimum standards.

There are problems with administrative redundancy and a lack of standardized reporting requirements. We have a lot about different reporting systems. If you're a CMHSP working with different funding streams needing a variety of different reports, it is problematic.

There are many reviews of CMHSPs. Should there be so many? In terms of standardization, the problem is on the local level. At the end of this fiscal year there will be a more accurate report of administrative costs. I don't know if CMHSPs have all that high administrative costs.

B. Funding

We have a limited eligibility program. Whatever system we come up with needs to address the optimal system needs. What can we do that will cost minimal dollars? What can we do to attract more general funds? Can we find money from reducing administrative inefficiencies?

So far we know we have to serve those with serious mental illness, serious emotional disorders, traumatic brain injuries, dementia, and prisoners, and if we're going to do community mental health we need a lot more money.

We are working with the current system because of the carve out and capitation. Both of those models made sense at the time, but health care is leaving those models behind. The carve out model has failed in a lot of ways. We need to fundamentally question if that model is the way to go. We've assumed that's the way to do it, but it's an old model. We have numerous levels of administration right now. We should look at the way health care is redesigning itself.

If we're looking at other financing mechanisms, why can't we look at the 1115 waiver. We need an alternative to the capitation system.

The state has made decisions based on maximizing Medicaid funding. The real issue is who is responsible. The state has tried to shift funding responsibility to the federal government and treatment responsibility to CMHSPs. There is not enough communication between decision makers. We've got to figure out how to divide up responsibility and have good communication between funding and treatment systems.

The commission's first value is to have a system shaped by the individuals it serves. What most people want is something that is adequate to meet their needs, something that is available on an equitable basis throughout the state. People aren't looking for the

Cadillac. We have funding to meet people's needs but the structure is so messed up from all the patchwork fixes over the years.

Within our recommendations we need to specifically mention the need for mental health parity. Serious mental illness along with a lack of insurance coverage can put people into poverty in a hurry.

D. Longer Term Care

It will be important to hear what the adult and children work groups have said on this issue. We need to use existing private and public facilities to provide this longer term care. There may be a time and place for the state to operate a new modern inpatient facility.

We need to not be afraid of having state hospitals. I think there is a fear that this will lead us back to institutionalization, but I don't think the pendulum will swing all the way back.

As far as longer term care, we need to look at it in terms of what the person's illness may demand over time. Some people may need long-term inpatient care. We shouldn't be afraid to talk about hospitalization. We just need to ask what treatment makes sense.

E. Involuntary Treatment

The first sentence of this section should be removed. ["The current process for involuntary commitment poorly serves consumers and the public interest."] A commissioner described her anger when she was involuntarily committed but now she ended up grateful.

We have about 75,000 mental health consumers in Wayne County on an annual basis. Of the 12,000 people who have had a petition for involuntary treatment over the past five years, 62 percent only had one petition.

Ranking

The commission was asked to complete a form to rank the importance of each of the key issues as high, moderate, low, or uncertain. The results of the ranking by the commissioners is as follows:

Education, Rights, Outreach, and Advocacy

Key Issues	Relative Importance Among All Key Issues			
	High	Moderate	Low	Uncertain
Inadequate rights protection	12	11	4	
Public attitudes and stigma	16	10	1	

Services and Supports for Children and Families

Key Issues	Relative Importance Among All Key Issues			
	High	Moderate	Low	Uncertain
Underfunding	19	7	1	
Lack of continuum of services	19	7	1	
Inconsistent use of standards of care and best practices	14	13		

Services and Supports for Adults

Key Issues	Relative Importance Among All Key Issues			
	High	Moderate	Low	Uncertain
A. Access to treatment, services, and supports (Quantity)	20	5		
B. Quality of treatment, services, and supports	16	11		
C. Accountability	16	9	1	

Criminal Justice and Human Service Interface

Key Issues	Relative Importance Among All Key Issues			
	High	Moderate	Low	Uncertain
A. General (overuse of costly & inappropriate services)	12	11	1	2
B. Pre-entry	9	12	4	1
C. Diversion	17	7	0	2
D. Incarceration & detention	13	10	3	1
E. Upon release	14	11	1	1
F. Beyond the CJ & HS interface	11	11	3	2

Governance, Structure, Finance, and Accountability

Key Issues	Relative Importance Among All Key Issues			
	High	Moderate	Low	Uncertain
A. Structure & governance	25	2		
B. Funding	23	4		
C. Accountability	16	11		
D. Longer term care	7	16	4	
E. Involuntary treatment/commitment	4	19	4	
F. Prevention and early intervention	19	7	1	

Pat Babcock told the commission that the Project Management Team will review the ranking results and the comments made during the discussion of the key issues to determine the next steps.

Discussion

A commissioner noted that he believes the input of state employees is lacking in the information the commissioners have received to date. In response, Pat Babcock said that the commission has a standing invitation to visit state facilities, and he asked Janet Olszewski to set up a date and time for commissioners to visit facilities such as Hawthorne or Reuther.

Other commissioners noted that they have been receiving valuable input from MDCH staff who staff their work groups.

Presentations

Sharon Gire, Director, Office of Services for the Aging

Sharon Gire's presentation is attached.

A commissioner asked Ms. Gire if she had a sense of how many older adults currently access CMH and if CMH systems collaborate with county aging offices. Ms. Gire responded that it varies from county to county, but that there are conversations under way at the state level about how to integrate these.

Another commissioner noted that the commission is not giving enough attention to the older adult population in our deliberations. He also stated that this population will require a level of integration that has never been achieved in the CMH system to date. He asked Ms. Gire for her thoughts on integration.

Ms. Gire suggested that we need to begin to identify and develop specific models for integration and that there are longer term issues that need to be hammered out over time.

Lauren Swanson, Direct Care Task Force

Lauren Swanson, a program specialist with Office of Services for the Aging, spoke about the current activities of the Michigan Direct Care Work Force Initiative (MDCWI). The MDCWI is a developing coalition of long-term care providers, provider associations, governmental agencies, consumer and advocacy organizations, worker organizations, workforce and education agencies, researchers, and interested members of the public.

Ms. Swanson also presented highlights from the report, "Voices from the Front: Recruitment and Retention of Direct Care Workers in Long-Term Care Across Michigan." The report is based on surveys of CNAs and home care aides about why they came to direct-care work, their reasons for staying within the field or reasons for leaving the field, and other opinions of the work. The report can be found at www.miseniors.net.

The coalition is working on applying for a grant from DLEG offering twelve regional skills alliances focused on how can we build a better work force for Michigan.

Public Comment

Sara B. Holmes—Representing the Michigan Dementia Coalition and the Alzheimer’s Research Center at the University of Michigan. Spoke from the perspective of persons with dementia and their families who are often caregivers. Spoke about: belief that there are barriers in the Mental Health Code that prevent persons with dementia from receiving services; need to expand services to persons with dementia; and need to support caregivers by providing respite services and other supports. Mental health system needs to be ready to serve an increased number of persons with dementia as the baby-boomer generation continues to age.

Chris Valentine—Family advocate from Huron County. Spoke about: (1) services to adults—need to have a full continuum of services that addresses the needs of people with a mental illness, (2) the need for a two phase reorganization of the public mental health system—consolidate the existing 46 CMH agencies into 18 PIHPs followed by a later consolidation into 7 PIHPs for the entire state, (3) performance and quality—recommends the creation of a mental health ombudsman to handle complaints, and (4) funding—CMHs shouldn’t be penalized for inpatient admissions. Mr. Valentine submitted written testimony.

Jamie Armstrong—Representing the Mental Health Association of Michigan. Recommends that all CMH staff receive sensitivity training to better serve consumers. Believes that CMH staff are often condescending toward consumers.

Peter Lichtenberg—Representing the Institute of Gerontology at Wayne State University. Spoke about persons with Alzheimer’s Disease and the services that they require. Need more focus by the mental health system on services to older adults.

Hubert Huebl, MD—President of the National Alliance for the Mentally Ill (NAMI) of Michigan. Spoke about the NAMI checklist that was distributed to commission members. Expressed concern with the commission’s time frame—too short to address all of the issues. Recommends that the commission’s report be considered preliminary with further work to follow.

Heather Irish—CEO of the MINDS Program, Inc. Spoke about stigma and how it needs to stop. Stigma prevents people from seeking the help that they need. A mandate from the legislature and the people of Michigan is needed to educate the public about mental illness. Need a huge campaign to fight stigma. Ms. Irish submitted a packet of information on MINDS to the commissioners.

Michael Dabbs—President of the Brain Injury Association of Michigan. Spoke about the need to examine the effect of Traumatic Brain Injury (TBI) on the mental health system. Believes that the CMH system can help persons with a TBI. Current system doesn’t recognize persons with a TBI as a service population—a TBI cognitive deficit not seen as a serious/persistent mental illness and not eligible for CMH services. More people are surviving after receiving a TBI so there is a greater need for long-term support services. Recommends that the commission include this population in its deliberations and consider (1) recognizing TBI as a mental illness—like disability, (2) helping to provide care

management to persons with a TBI through the CMH system, and (3) providing access to and reimbursement for assistive technology devices to persons with a TBI.

Norm DeLisle—Executive director of the Michigan Disabilities Rights Coalition. Also a person with a mild head injury and a mental illness (depression and post-traumatic stress disorder). Spoke about the value of support groups for his PTSD and the importance of providing support services to consumers and their families. Fears that the mental health system will sacrifice excellence for efficiency—need both for the system to work. Need to focus on reaching out to all persons who should be served including persons with TBIs. Mr. DeLisle stated that we need “hard dialogue” about funding because the need exceeds the current resources.

Christine Riddlebaugh—Gratiot County Community Mental Health volunteer. Supports the current system of local CMH agencies. Recommends that the commission not move to a regional structure with fewer PIHPs and fewer CMHs. Asks that the commission keep consumers informed about what is going on—maybe send an e-mail to each CMH with monthly updates on commission meetings and activities.

Kristy Sumera—Consumer from Traverse City. Spoke about the problems that she experienced in receiving CMH services in Traverse City. She became a CMH board member in an effort to provide a consumer perspective, but feels that she was run off the board because she asked hard questions and raised issues that were unpopular. Spoke about her feeling that the current recipient rights system protects staff more than consumers. Also believes that outcomes and accountability are not focused on enough by MDCH with regard to the CMH system.

Tammy Woodhams—Representing the Kalamazoo Criminal Justice Council. She testified at the invitation of Mr. Patton, who wanted the commission to hear about a program that works. Spoke about the proposed cut in funding by the Michigan Department of Corrections for a local Kalamazoo corrections residential treatment center that has been in operation for 30 years. The program has been evaluated and found to reduce drug problems and prison recidivism by the offenders who are served by this program. Ms. Woodhams submitted a copy of her letter to the commission.

Mary Ellen Judd—Spoke on behalf of her husband, Leon, who could not attend and is an officer of NAMI of Oakland County. Spoke about how persons with a mental illness want to contribute to society and how the mental health system has let them down. Identified problems and concerns based on a NAMI survey including: availability of long-term psychiatric hospital care, access to acute psychiatric hospital beds, access to medical and dental care, availability of group homes in the community, transportation, adequate jail diversion programs and police training on mental health issues, availability of assertive community treatment (ACT) services and psychosocial rehabilitation programs, and availability of dual diagnosis services. Provided commission members with a NAMI checklist of their concerns and issues. Asked commission to consider who is accountable and who is going to help. Also, what will happen to our children when we die and can no longer advocate for them?

Susan Kurtzman—Representing Birmingham Maple Clinic and Davis Counseling Center, outpatient mental health agencies in Oakland County where she works. Spoke

about her concern for maintaining a “safety net” for those persons most in need. Also spoke about the need for mental health parity in insurance coverage—there are many limits on current mental health coverage that result in people moving to the public system. Important to provide education and prevention services to families and mental health personnel. Supports that there only be one department—Department of Community Health.

James Kendrick—Professor at Western Michigan University. Believes that universities are not adequately involved in the mental health system. Many university student interns are available, but they need good training opportunities at community agencies—need to expand the number of agencies willing to participate as training facilities. Also need to involve the family more when offering mental health services—they are involved and can help improve outcomes. He expressed his concern about the “criminalization” of unhealthy behavior.

Dan Moran—Consumer from Oakland County. Spoke about the importance of giving people the chance to run their own lives. He stated that person-centered planning is not being implemented all the time and that we still have consumers saying “I can’t do that because *they* won’t let me.” Agency staff does not know what people need—people know what they need. Asks that consumers be more involved in deciding what services and supports are needed.

Cynthia Archer-Gift, PhD, RN—Staff of MDCH Office of Psychiatric and Medical Services. Speaking on behalf of psychiatric nurses. Focused on access to mental health services. Spoke about her volunteer activities at a hospital that serves consumers with a mental illness who are not being served by the public mental health system (e.g., former clients of closed psychiatric hospitals). We need to do more to reach all consumers who have a need for services. Need to improve access to effective treatment and support and focus on early detection and recovery.

Dixie Pemberton—Mother of sons who are consumers of mental health services. Spoke about her extensive experience in dealing with the public mental health system.

David LaLumia—Executive director of the Michigan Association of Community Mental Health Boards (MACMHB). Spoke about the shrinking general fund (GF) dollars available to CMHs. Recently has learned that CMH GF dollars are to be reduced even more. Recommends that GF dollars remain in the budget for mental health including any GF dollars that are lapsed by CMHs.

Adjournment

The next commission meeting will be held on July 26 in Lansing at the Holiday Inn South.

PRESENTATION MADE BY SHARON GIRE, DIRECTOR, OFFICE OF SERVICES FOR THE AGING

*Michigan Mental Health Commission Meeting
Holiday Inn South
June 28, 2004*

I. Introduction

"One in four older adults has a significant mental disorder. By the year 2030, the number of older adults with major psychiatric illnesses is predicted to reach 15 million. The growth of this subgroup will significantly affect the mental health and general healthcare service delivery systems. Older adults with mental illness are at increased risk, compared with younger adults, for receiving inadequate and inappropriate care. Without effective treatment, mental disorders in older persons are associated with significant disability and impairment, compromised quality of life, cognitive impairment, increased caregiver stress, increased mortality and poor health outcomes. Older adults with mental health problems also have higher utilization costs of healthcare services, but providing effective mental health services can result in cost offsets."

- A. The source of this assessment of the mental health needs of older adults is Dr. Stephen J. Bartels in an article in the American Journal of Geriatric Psychiatry, September-October 2003.
- B. It is a clear statement about the importance for considering older adults in the Michigan mental health system.

II. Background

- A. Twenty years ago, Michigan embarked on improving mental health services for older adults.
- B. At that time, it was noted that 25% of state psychiatric hospital residents were over the age of 60 and few community mental health services for older adults existed.
- C. Today, there are only a handful of older adults in state psychiatric facilities.
- D. Yet in many areas, community mental health services are still inaccessible or inadequate for older adults.
 - a. In 1999 the statewide average penetration rate in the mental health system for 65+ was at .68, and .64 in 2002.
 - b. It is clear there is no new money and may be less since 2002. There is a need to be even more efficient and effective in reaching, teaching, and supporting older adults with mental illness and their families.

III. OSA Goals

OSA, with the help of providers, has identified three broad categories with one major goal:

- A. Older adult mental health services, resources, and programs should be seen as critical as any other Michigan population group and must be on the Mental Health Commission agenda. Ensuring accessibility and high quality care and not allowing any further loss of ground is imperative.
 1. The demographics are clear: there is a growing older population.
 - By 2020 the 60+ age group will represent 25% of the population. 10-28% of this population will have mental health problems that warrant professional help.
 - By 2030 the number of older adults with major psychiatric illness is predicted to reach 15 million nationally.
 2. Yet the percentage of people age 65+ served by the public mental health system has decreased in the last three years.
- B. To meet that goal, three broad categories are offered for consideration:
 1. Chronic conditions
 2. Life span/prevention and
 3. Systemic barriers

IV. Chronic Conditions

- A. Chronic conditions encompass the elderly population with long term mental health problems and service needs:
 1. People who have been hospitalized sporadically throughout their lives
 - Medical treatment outcomes are worse when complicated by mental health problems.
 2. People who are currently diagnosed with a serious mental illness, regardless of residence; and
 3. Those older individuals who need episodic treatment for co-occurring illnesses, such as mental illness and substance abuse.
 4. It also covers those with chronic physical illnesses who, by virtue of their illness, have become depressed or suicidal.
 - Older adults (65 and older) make up approximately 13 % of the general population, but account for approximately 20 % of all reported suicides. Most of these are the result of undetected depression. This is truly tragic.

5. Robert Butler, noted Geriatrician, states that of people 65 and older, in any given year, 35% of them will have an adverse drug reaction.

B. Depression:

1. Of nearly 34 million older adults, it is estimated 2 million have a depressive illness.
2. Depression is not normal and can interfere significantly with a person's ability to function.
 - About 58% of people aged 65+ believe that it is "normal" for people to get depressed as they grow older.
 - Only 40% of older adults with depression will seek help from health professionals.

C. Suicide

1. Individuals age 65 and better account for 13% of the population and 18% of all suicide deaths.
2. White men age 85 and better have a suicide rate five times the national average.
3. The National Institutes of Mental Health has cited the "urgency of improving detection and treatment of depression as a means of reducing suicide risk among older persons." (NIMH, Older Adults and Suicide Facts, 2003)

D. Other areas of concern include:

1. Medication issues
 - a. Medication mismanagement;
 - b. Inadequate or inappropriate medications; and
 - c. Lack of access to needed medications.
2. Lack of access to health care and mental health care

E. Many of these issues are not just the concern of the mental health system

1. They are issues that encompass the long term care system as well.
2. We cannot overlook the health care costs that accompany physical illnesses, nor should we ignore the high cost of untreated depression among the elderly.
 - Older patients with symptoms of depression have roughly 50% higher healthcare costs than non-depressed seniors.
3. Older adults are more likely to receive medical care rather than mental health care, even when the problem is not physical.

4. As a member of the newly appointed Governor's Medicaid Long Term Care Task Force, I hope that some dialogue between these two appointed groups can occur. We share many of the same concerns.

F. Dementia

1. Dr. Peter Lichtenberg, Wayne State Institute of Gerontology, noted that the biggest cause of psychosis and behavioral disturbance in older adults is dementia.
2. With the demographic changes sweeping the country and Michigan, this will only increase.
3. 3 Dementia from Alzheimer's, stroke, Parkinson's disease or any of 70 illnesses, creates stress and depression not only for the affected person, but for their family.

V. Lifespan issues/Prevention

- A. Next, the Commission's recommendations should, at a minimum, mirror the President's New Freedom Commission on Mental Health report, by citing the importance of **a life span perspective**.
 1. As stated in the President's Commission report: "Mental illnesses are shockingly common; ...(they) can occur at any stage of life, from childhood to old age." (Executive Summary, the President's New Freedom Commission on Mental Health, 2003)
- B. As we look at this Commission's work groups, we find that older adults are part of each of those groups.
 1. As aging prisoners are released into the community;
 2. Older adults raising their grandchildren;
 3. Families struggling to raise children while providing care for elderly parents;
 4. Older adults play vital roles as caregivers for their adult children with serious mental illness--especially since the State Mental Hospital system has been dismantled. Family support is often the vital link.
 - Studies show that up to half of caregivers suffer from some form of depression. This is again more costly to the mental health system if unrecognized and untreated in terms of greater numbers of suicides and more expensive psychiatric and health-related problems that need to be treated.
 - Also, if caregivers quit, it costs the long-term care system much more to institutionalize the elderly person they are caring for;
 5. We have an interest in recipient rights issues to ensure that being old doesn't mean being overlooked

- a. After all, it was older women who filed the Olmstead suit; and
- 6. Whether the older adult is the caregiver or the care recipient, we know that care giving is a source of great stress.
- C. A life span perspective recognizes the interrelationships across the system.

VI. Systemic Barriers

- A. **Systemic barriers** have been a problem for decades.
 - 1. Fragmentation of services is acknowledged for children and adults.
 - 2. This is true for older adults, in addition to a lack of adequate services in many areas.
 - 3. Mental health and physical health are clearly connected, yet the system fails to recognize that the connection is especially strong for older adults who are likely to have a chronic disease and several daily medications.
 - Patrick Arbore, Suicidologist expert, relays the following from a study that was conducted: Medical patients present with psychiatric disorders in **27%** of cases though they are unrecognized by medical staff **60%** of the time. Since older adults are primary users of the medical system, it's easy to see how their psychiatric problems can be missed.
 - 70% of elderly completing suicide have seen their primary care physician in the prior month, 40% prior week and 20% on the same day.
 - 4. OSA has developed and maintained an integral and productive relationship with the Mental Health Services Bureau of DCH over many years.
 - 5. We recognize that some model projects have been successful in bringing local and/or state stakeholders together. These model projects have been progressively replaced by a Federal Block model which is time limited, insufficiently funded, and does not contribute to Michigan's sustained capacity response to increasing acuity, demand for services or progressive weakening of the safety net in all sectors.

VII. Recommendations

OSA is concerned that mental health services for older adults not continue to lose ground. In times of deficits, funding for the least vocal and perhaps the most vulnerable groups often is in jeopardy.

We urge the Commission to assure that their report reflects a life span perspective on services and needs. We ask that the commission

recognize that the older population, while represented in each of the concerns of the work groups, is also a population with some distinct service needs. And finally, support the continuation of the existing resources for aging specific programs and services. **The following are more specific recommendations:**

1. Ask all CMH systems to be consistent in focused outreach to this underserved population (older adults, persons with dementia, caregivers). And develop consistent communication and reporting mechanisms.
2. Ask CMH systems to demonstrate how their screening and intake systems are elder- friendly, especially to persons and family members who present with cognitive impairment.
3. Ensure that mental health systems access is facilitated for older adults.
4. Replicate best practice models that provide medical doctors with key screening tools that increase the ability to identify potential depression, other mental health problems, and substance abuse problems in the elderly.
5. Encourage increased integration, communication and education between primary and behavioral health care to more effectively co-manage the complex medical conditions found in the elderly population.

VIII. Closing Remarks

I appreciate the Commission's willingness to integrate the needs of an aging population and placing the needs of older adults on the same plane of consideration as infants, younger children, and adults into their recommendations. OSA stands ready to provide additional information and assistance to achieve the goal.

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